portant to ensure that policy implementation did not compromise patient outcomes.
OBJECTIVES: The goals of this study were: 1) to assess the net economic impact of PA for NSAIDs on WVM expenditures, and 2) to determine the impact of the policy on patients' health-related quality of life (HRQoL).
METHODS: The study was conducted in two phases. In phase I, a quasi-experimental design was used to analyze retrospective utilization data of recipients with continuous Medicaid eligibility over the period of 18 months prior to and 18 months after implementation, who were diagnosed with rheumatoid arthritis, osteoarthritis, spondylitis, or any other chronic pain syndrome. Segmented regression analysis was used to model the impact of policy on WVM expenditures. In phase II, patients who were newly diagnosed with any of the above-mentioned disorders, and for whom a request for PA was received, were identified and classified into two groups. Group I consisted of patients who were approved a branded NSAID. Group II consisted of patients who were denied a branded NSAID and switched to a generic product. HRQoL was measured at the time the patient was identified and two months later using the Arthritis Impact Measurement Scales (AIMS).

PAD7

PHARMACOEPIDEMIOLOGY OF INITIAL DISEASE MODIFYING ANTIRHEUMATIC DRUG (DMARD) THERAPY IN A MANAGED CARE ORGANIZATION (MCO)

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New therapies are available to manage rheumatoid arthritis (RA) patients who fail currently available DMARD therapies. Data on patterns of DMARD use will be useful in evaluating new therapies.
OBJECTIVE: Identify patterns of initial DMARD therapy in RA patients.
METHODS: We used claims data from an MCO to identify RA patients who 1) were >18 years of age, 2) were prescribed a DMARD for 2 consecutive months between July 1993 and February 1998, 3) had a diagnosis of RA during 6 months prior to DMARD therapy, and 4) had 6 months of enrollment before initial DMARD therapy. Among patients using alternative therapies, we compared patient characteristics, duration of therapy and changes in initial therapy.
RESULTS: 564 patients met the inclusion criteria. Mean age was 51 years; 60% were female; and 78% received their initial prescription from a rheumatologist. Median duration of initial therapy was 16 months for methotrexate (n = 196), 11 months for hydroxychloroquine (n = 260), 5 months for sulfasalazine (n = 51), and 5 months for other therapies (n = 57). For the two most commonly used DMARDS, hydroxychloroquine patients were significantly more likely (adjusted odds ratio 1.44, p = 0.004) than methotrexate patients to discontinue all DMARD therapy, switch to an alternative DMARD, or begin taking one or more additional DMARDS.
CONCLUSIONS: Many RA patients change initial DMARD therapy within 1 year, suggesting a potential role for new therapies directed toward patients who fail currently available first-line drugs.

PAD8

INTERPRETATION OF HAQ DISABILITY INDEX IMPROVEMENT AMONG RHEUMATOID ARTHRITIS (RA) PATIENTS IN RANDOMIZED CLINICAL TRIALS

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The Health Assessment Questionnaire Disability Index (HAQ) has been proven to be a valid and reliable measure of daily living ability of arthritis patients.
OBJECTIVE: To establish the clinically meaningful improvements of the HAQ and its domain scores among RA patients.
METHODS: Data were obtained from two 12-week randomized clinical trials among 2252 RA flare patients. The HAQ, Patient and Physician Global Assessments (PtGA & PhGA) were administered to patients at baseline and week 12. HAQ is a 20-item instrument that contains eight categories of daily living activities. A composite score is calculated. PtGA & PhGA were measured on the following 1- to 5-point scale: very good, good, fair, poor, or very poor. Change scores were computed by subtracting patients' baseline from week 12 follow-up scores. Responsiveness was estimated as the mean change score corresponding to each level of improvement in PtGA or PhGA.
RESULTS AND CONCLUSIONS: At week 12, the number of patients experiencing improvements in PtGA and PhGA were: 783 and 796 for one-level, 387 and 388 for two-levels, and 87 and 85 for three or more levels. The average improvement in HAQ disability index among patients experiencing one, two, or three or more levels were 0.25, 0.47, 0.76 for PtGA and 0.26, 0.46, and 0.64 for PhGA. Using the change score corresponding to a one-level improvement or using the average difference of change between any two levels of improvement of PtGA or PhGA, the clinically meaningful improvement score ranged from 0.21 to 0.26. Using similar methods, the clinically meaningful improvement scores for the following eight categories of daily living were: dressing (0.29), eating (0.22), arising (0.35), walking (0.24), hygiene (0.15), reach (0.21), grip (0.24), and activities (0.28), respectively.